APPENDIX F

MEDICAL REQUIREMENTS

1. Examining physician **MUST** be certified as an FAA Medical Examiner or a designated Flight Surgeon.
2. Category I Personnel: Air Force Class III Flight Physical (see page F-2).
3. Category II Personnel: FAA Third Class Aviation Physical and a few required additional tests (see page F-5).
4. Records of these physical must be on file at the Johnson Space Center prior to participation in physiological training or boarding the KC-135 aircraft (Reduced Gravity Aircraft).

   Results of the physical exam must be sent to the following address at least four weeks prior to flight date:

   Johnson Space Center
   ATTN: Physiological Training Officer
   Code SD-25
   Houston, TX 77058

   FAX (281) 483-3397

   All medical questions posed by examiners should be directed to Physiological Training Officer at (281) 483-6344. The Chief of Aircraft Operations reserves the right to refer any KC-135 manifested person to the JSC Medical Office for a medical determination of the person's fitness for flight. The Chief of Medical Sciences Division at JSC is the final authority on whether or not a person is physically qualified to fly on the KC-135 Reduced Gravity Aircraft.

CATEGORY I
PHYSICAL REQUIREMENTS FOR
AIR FORCE CLASS III FLIGHT PHYSICAL

Category I Personnel:

Pilots

Astronauts

Payload Specialist

Aircrew

Suited subjects

Photographers

KC-135 Test Directors (FCOD personnel)

Flight Engineers

Aircraft Crewchiefs

Medical Officers

Any test subject involved in a flight requiring Level I or Level II medical coverage as mandated by the IRB

Frequency:

Yearly examinations are required.

Requirements:

Physician screening including:
Health history, hiatal hernia examination (patient by provide a copy of the report from their personal physician), immunization, temperature, history of hypertension or heart problems, etc.

Health Screening including:

Initial X-ray (inspiration and expiration for blebs), thereafter as indicated by history or requested by examining physician.
Laboratory analysis (see page F-4).
EKG
Blood pressure (sitting, recumbent and standing)
Pulse (sitting, recumbent and standing) - Exercise by jumping 100 times on either foot, clearing the floor by at least one inch, and take immediate pulse, rest two minutes and take pulse again.
Audiogram
Visual screening (tonometry, heterophoria, accommodation, color vision, depth perception)

LABORATORY ANALYSIS

Chemistry:

Glucose	61-114 m/dl
Bun	08-23 mg/dl
SGOT	06-26 IU/L
Chloesterol	108-252 mg/dl
SGPT	06-391 U/L
Triglycerites	36-165 mg/dl
HDL	30-85 mg/dl
Ratios	CHOL:HD
Uric Acid	2.4-70 mg
RPR/VDRL	Non-reactive

Hematology

HGB	M = 16 (± 2)
	F = 14 (± 2) GM
HCT	M = 47 (± 7)
	F = 42 (± 5) %
WBC	4,500 - 10,000 / cubic mm
RBC	4,200,000 - 6,000,000 / cubic mm
MCV	85 - 100 cubic m
NEUT	54 - 62
LYMPHS (Atypical)	25 - 33
MONO/EOS	03 - 07/01 - 03
BASO/BANDS	00 - 02
MORPH PLATELETS	-

Urinalysis

Specific Gravity	1.010 - 1.025
pH	-
Glucose/Ketone	-
Protein/Bilirubin	-
Blood	-
WBC/RBC	-
Mucus	-
Epithelial Cells	-
Bacteria	-
Casts	-

CATEGORY II
PHYSICAL REQUIREMENTS FOR
FAA CLASS III FLIGHT PHYSICAL

Reference: *FAA Guide for Physical Examiners* (see page F-7)

Category II Personnel:

Principal Investigators

Research Assistants

Observers

Students -- **18 years and older** -- involved in NASA sponsored programs

Media representatives

Test subjects not involved with Level I or Level II type experiments

Any other personnel not included in the mandatory USAF Class III physical category and not mentioned in this group

Frequency:

Examinations are required every three (3) years.

Requirements:

Physical Examination & Medical History

Use SF-88, SF-93 or FAA Form 8500-8 or JSC Form 8500. See pages F-9 through F-16.

Additional Requirements:

Initial X-Ray (inspiration and expiration for blebs), thereafter as indicated by history or requested by examining physician.

WEIGHT Requirement: MAXIMUM allowable weight is 15% over MAXIMUM weight (see Height and Weight Tables on page F-8)

EKG: Required at age 35 and annually after age 40

REPORTING RESULTS

The examining physician may use the Standard Form 88 (Report of Medical Examination, pages F-9 and F-10) and Standard Form 93 (Report of Medical History, pages F-11 and F-12) **or** FAA Form 8500-8 (report of Medical History and Examination, pages F-13and F-14) **or** JSC Form 8500 (Report of Medical Examination, pages F-15 and F-16) to report the results of the physical examination. Physicians using other forms must include the results of all the parameters listed on pages F-9 through F-16. **Each Page must contain the patient's name**.

The following information must be included in the blocks specified:

Information	SF-88 Block #	FAA Form 8500 Block #	JSC Form 8500 Block #
Urinalysis	45	57	48
X-ray, original (date completed)	46	59	50
EKG (date completed)	48	58	49
Vital Capacity *	50	59	50
Audiogram	71	49	40

The results of the lab analysis for Block Hematology and Chemistry can be recorded in block 73 of SF-88, in the "Notes" of the FAA Form 8500-8 or JSC Form 8500 **as negative**.

* Category I only.

NOTE: Comments on History and Findings

On the SF-93 Item #25, FAA Form 8500-8 Item #60 and JSC Form 8500 item #51, the examining Physician **shall comment** of all "**YES**" answers in the "Medical History" section and for abnormal findings of the examination.

MEDICAL AND PHYSIOLOGICAL DOCUMENTATION

All medical records of personnel stationed at JSC will be kept by the JSC Occupational Medical Clinic (Bldg. 8) or the Human Test Subject facility (Bldg. 37). All other medical records will be forwarded to:

Johnson Space Center
ATTN: Physiological Training Officer
Code SD-25
Houston, TX 77058

FAX (281) 483-3397

Personnel receiving Physiological Training from other organizations must send a copy showing successful completion of the training to the above address.

GUIDE FOR AVIATION MEDICAL EXAMINERS

Medical Certification Pilot Type	Medical Standards - Effective September 16, 1996		
	First-Class Airline Transport Pilot	Second-Class Commercial Pilot	Third-Class Private Pilot
DISTANT VISION	20/20 or better in each eye separately, with or without correction		20/40 or better in each eye separately, with or without correction
NEAR VISION	20/40 or better in each eye separately (Snellen equivalent), with or without correction, as measured at 16 inches		
INTERMEDIATE VISION	20/40 or better in each eye separately (Snellen equivalent), with or without correction at age 50 and over, as measured at 32 inches.		No requirement
COLOR VISION	Ability to perceive those colors necessary for safe performance of airman duties.		
HEARING	Demonstrate hearing of an average conversational voice in a quiet room, using both ears at 6 feet, with the back turned to the examiner or pass one of the audiometric test below.		
AUDIOLOGY	Audiometric speech discrimination test: Score at least 70% discrimination in one ear.		
	Pure tone audiometric test: Unaided, with threshold no worse than:		
	500 Hz / 1,000 Hz / 2,000 Hz / 3,000 Hz		
	Better ear: 35 db / 30 db / 30 db / 40 db		
	Worse ear: 35 db / 50 db / 50 db / 60 db		
ENT	No ear disease or condition manifested by, or that may reasonably be expected to be manifested by, vertigo or a disturbance of speech or equilibrium.		
PULSE	No disqualifying per se. Used to determine cardiac system status and responsiveness.		
BLOOD PRESSURE	No specified values stated in the standards. Hypertension covered under general medical standard and in *the Guide for Aviation Medical Examiners*.		
ELECTRO-CARDIOGRAM (ECG)	At age 35 and annually after age 40	Not routinely required.	
MENTAL	No diagnosis of psychosis, or bipolar disorder, or severe personality disorders.		
SUBSTANCE DEPENDENCE AND SUBSTANCE ABUSE	A diagnosis or medical history of "substance dependence "is disqualifying unless there is established clinical evidence, satisfactory to the Federal Air Surgeon, of recovery, including sustained total abstinence from the substance(s) for not less than the preceding 2 years. A history of "substance abuse" within the preceding 2 years is disqualifying. "Substance " includes alcohol and other drugs (i.e., PCP, sedatives and hynoptics, anxiolytics, marijuana, cocaine, opioids, amphetamines, hallucinogens, and other psychoactive drugs or chemicals).		
DISQUALIFYING CONDITIONS * *** BOLD print depicts new disqualifying conditions as of September 16, 1996. Substance dependence and substance abuse replace dependence and alcoholism**.	Examiner must disqualify if the applicant has a history of: (1) Diabetes mellitus requiring hypoglycemic medication; (2) Angina pectoris; (3) Coronary heart disease that has been treated or, if untreated, that has been symptomatic or clinically significant; (4) Myocardial infarction; (5) Cardiac valve replacement; (6) Permanent cardiac pacemaker; (7) Heart replacement; (8) Psychosis; (9) Bipolar disorder; (10) Personality disorder that is severe enough to have repeatedly manifested itself by overt acts; (11) Substance dependence; (12) Substance abuse; (13) Epilepsy; (14) Disturbance of consciousness without satisfactory explanation of cause; and (15) Transient loss of control of nervous system function(s) without satisfactory explanation of cause.		

JSC Form 2156 (Sep 97)(MS Word Sep 97)

Height and Weight Tables

		Men				Women			
Height		Minimum		Maximum		Minimum		Maximum	
In	cm	lbs	Kg	lbs	Kg	lbs	Kg	lbs	Kg
58	147.32	98	44.54	149	67.72	88	39.99	132	60.00
59	149.86	99	44.99	151	68.62	90	40.90	134	60.90
60	152.40	100	45.45	153	69.54	92	41.48	136	61.81
61	154.94	102	46.36	155	70.54	95	43.18	138	62.72
62	157.48	103	46.81	158	71.81	97	44.09	141	64.09
63	160.02	104	47.27	160	72.72	100	45.45	142	64.54
64	152.56	105	47.72	164	74.54	103	46.81	146	66.36
65	156.10	106	48.18	169	76.81	106	48.18	150	68.18
66	167.64	107	48.63	174	79.09	108	49.09	155	70.45
67	170.18	111	50.45	179	81.36	111	50.45	159	72.27
68	172.72	115	52.27	184	83.63	114	51.81	164	74.54
69	175.26	119	54.09	189	85.90	117	53.18	168	76.36
70	177.60	123	55.90	194	88.18	119	54.09	173	78.63
71	180.34	127	57.72	199	90.45	122	55.45	177	80.45
72	182.88	131	59.54	205	93.18	125	56.81	182	82.72
73	185.42	135	61.36	211	95.90	128	58.18	188	85.45
74	187.96	139	63.18	218	99.09	130	59.09	194	88.18
75	190.50	143	65.00	224	101.81	133	60.45	199	90.45
76	193.04	147	66.81	230	104.54	136	61.81	205	93.18
77	195.58	151	68.83	236	107.27	139	63.18	210	95.45
78	198.12	153	69.54	242	110.00	141	64.09	215	97.72
79	200.66	157	71.36	248	112.72	144	65.45	221	100.45
80	203.20	161	73.18	254	115.45	147	66.81	226	102.72

NOTE: Maximum allowable weight is 15% over maximum.

REPORT OF MEDICAL EXAMINATION

1. LAST NAME–FIRST NAME–MIDDLE NAME			2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO
4. HOME ADDRESS *(Number, street or RFD, city or town, State and ZIP Code)*			5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION
7. SEX	8. RACE	9. TOTAL YEARS GOVERNMENT SERVICE: MILITARY / CIVILIAN	10. AGENCY	11. ORGANIZATION UNIT
12. DATE OF BIRTH	13. PLACE OF BIRTH		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS			16. OTHER INFORMATION	
17. RATING OR SPECIALTY			TIME IN THIS CAPACITY *(Total)*	LAST SIX MONTHS

CLINICAL EVALUATION

NORMAL	*(Check each item in appropriate column, enter "NE" if not evaluated.)*	ABNORMAL
	18. HEAD, FACE, NECK AND SCALP	
	19. NOSE	
	20. SINUSES	
	21. MOUTH AND THROAT	
	22. EARS–GENERAL *(INTERNAL CANALS) (Auditory acuity under items 70 and 71)*	
	23. DRUMS *(Perforation)*	
	24. EYES–GENERAL *(Visual acuity and refraction under items 59, 60 and 67)*	
	25. OPHTHALMOSCOPIC	
	26. PUPILS *(Equality and reaction)*	
	27. OCULAR MOTILITY *(Associated parallel movements nystagmus)*	
	28. LUNGS AND CHEST *(Include breasts)*	
	29. HEART *(Thrust, size, rhythm, sounds)*	
	30. VASCULAR SYSTEM *(Varicosities, etc.)*	
	31. ABDOMEN AND VISCERA *(Include hernia)*	
	32. ANUS AND RECTUM *(Hemorrhoids, Fistulae) (Prostate, if indicated)*	
	33. ENDOCRINE SYSTEM	
	34. G-U SYSTEM	
	35. UPPER EXTREMITIES *(Strength, range of motion)*	
	36. FEET	
	37. LOWER EXTREMITIES *(Except feet) (Strength, range of motion)*	
	38. SPINE, OTHER MUSCULOSKELETAL	
	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
	40. SKIN, LYMPHATICS	
	41. NEUROLOGIC *(Equilibrium tests under item 72)*	
	42. PSYCHIATRIC *(Specify any personality deviation)*	
	43. PELVIC *(Females only) (Check how done)* ☐ VAGINAL ☐ RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

(Continue in item 73)

44. DENTAL *(Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)*

Restorable Teeth (e.g. 1 0 2 3 / 32 31 0 30) — *Non-restorable teeth* (e.g. 1 / 2 3 / 32 31 / 30) — *Missing Teeth* (e.g. 1 x 2 3 / 32 31 x 30) — *Replaced by Dentures* (e.g. 1 x 2 x 3 x / 32 x 31 x 30 x) — *Fixed Partial dentures* (e.g. (1 x 2 3) / 32 x 31 30)

RIGHT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	LEFT
	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	

REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY			46. *CHEST X-RAY (Place, date, film number and result)*
B. ALBUMIN	D. *MICROSCOPIC*		
C. SUGAR			
47. SEROLOGY *(Specify test used and result)*	48. *EKG*	49. *BLOOD TYPE AND RH FACTOR*	50. OTHER TESTS

NSN 7540-00-753-4570
88-125

Standard Form 88 *(Rev. 3-89)*
General Services Administration
Interagency Comm. on Medical Records
FIRMR (41CFR) 201-45.505

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT	52. WEIGHT	53. COLOR HAIR	54. COLOR EYES	55. BUILD: ☐ SLENDER ☐ MEDIUM ☐ HEAVY ☐ OBESE	56. TEMPERATURE

57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)				
A. SITTING	SYS. / DIAS.	B. RECUMBENT	SYS. / DIAS.	C. STANDING (5 min.)	SYS. / DIAS.	A. SITTING	B. AFTER EXERCISE	C. 2 MIN. AFTER	D. RECUMBENT	E. AFTER STANDING 3 MIN.

59. DISTANT VISION		60. REFRACTION			61. NEAR VISION	
RIGHT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY
LEFT 20/	CORR. TO 20/	BY	S.	CX	CORR. TO	BY

62. HETEROPHORIA (Specify distance)

ES*	EX*	R.H.	L.H.	PRISM DIV.	PRISM CONV. CT	PC	PD

63. ACCOMMODATION		64. COLOR VISION (Test used and result)	65. DEPTH PERCEPTION (Test used and score)	UNCORRECTED
RIGHT	LEFT			CORRECTED
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)	68. RED LENS TEST	69. INTRAOCULAR TENSION

70. HEARING			71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)
RIGHT WV	/15 SV	/15		250 256	500 512	1000 1024	2000 2048	3000 2896	4000 4096	6000 6144	8000 8192	
LEFT WV	/15 SV	/15	RIGHT									
			LEFT									

73 NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

75. RECOMMENDATIONS—FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)	76. A. PHYSICAL PROFILE					
	P	U	L	H	E	S

77. EXAMINEE (Check)	B. PHYSICAL CATEGORY
A. ☐ IS QUALIFIED FOR B. ☐ IS NOT QUALIFIED FOR	

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER	A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
80. TYPED OR PRINTED NAME OF PHYSICIAN	SIGNATURE
81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)	SIGNATURE
82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY	SIGNATURE / NUMBER OF ATTACHED SHEETS

SF 88 (Rev. 3-89) PAGE 2

STANDARD FORM 93
REV. OCTOBER 1974
PRESCRIBED BY GSA/ICMR
FIRMR (41 CFR) 201-45.505

APPROVED
OFFICE OF MANAGEMENT AND BUDGET No. 29- R0191

REPORT OF MEDICAL HISTORY

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY-CONFIDENTIAL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME		2. SOCIAL SECURITY OR IDENTIFICATION NO.
3. HOME ADDRESS *(No. street or RFD, city or town, State, and ZIP CODE)*		4. POSITION *(title, grade, component)*
5. PURPOSE OF EXAMINATION	6. DATE OF EXAMINATION	7. EXAMINING FACILITY OR EXAMINER, AND ADDRESS *(Include ZIP Code)*

8. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED *(Follow by description of past history, if complaint exists)*

9. HAVE YOU EVER *(Please check each item)*

YES	NO	(Check each item)
		Lived with anyone who had tuberculosis
		Coughed up blood
		Bled excessively after injury or tooth extraction
		Attempted suicide
		Been a sleepwalker

10. DO YOU *(Please check each item)*

YES	NO	(Check each item)
		Wear glasses or contact lenses
		Have vision in both eyes
		Wear a hearing aid
		Stutter or stammer habitually
		Wear a brace or back support

11. HAVE YOU EVER HAD OR HAVE YOU NOW *(Please check at left of each item)*

YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever, erysipelas				Cramps in your legs				"Trick" or locked knee
			Rheumatic fever				Frequent indigestion				Foot trouble
			Swollen or painful joints				Stomach, liver, or intestinal trouble				Neuritis
			Frequent or severe headache				Gall bladder trouble or gallstones				Paralysis (include infantile)
			Dizziness or fainting spells				Jaundice or hepatitis				Epilepsy or fits
			Eye trouble				Adverse reaction to serum, drug,				Car, train, sea or air sickness
			Ear, nose, or throat trouble				or medicine				Frequent trouble sleeping
			Hearing loss				Broken bones				Depression or excessive worry
			Chronic or frequent colds				Tumor, growth, cyst, cancer				Loss of memory or amnesia
			Severe tooth or gum trouble				Rupture/hernia				Nervous trouble of any sort
			Sinusitis				Piles or rectal disease				Periods of unconsciousness
			Hay Fever				Frequent or painful urination				
			Head injury				Bed wetting since age 12				
			Skin diseases				Kidney stone or blood in urine				
			Thyroid trouble				Sugar or albumin in urine				
			Tuberculosis				VD—Syphilis, gonorrhea, etc.				
			Asthma				Recent gain or loss of weight				
			Shortness of breath				Arthritis, Rheumatism, or Bursitis				
			Pain or pressure in chest				Bone, joint or other deformity				
			Chronic cough				Lameness				
			Palpitation or pounding heart				Loss of finger or toe	12. FEMALES ONLY: HAVE YOU EVER			
			Heart trouble				Painful or "trick" shoulder or elbow				Been treated for a female disorder
			High or low blood pressure				Recurrent back pain				Had a change in menstrual pattern

13. WHAT IS YOUR USUAL OCCUPATION?

14. ARE YOU *(Check one)*
☐ Right handed ☐ Left handed

93-103

YES	NO	CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE ON RIGHT	
		15. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.	
		B. Inability to perform certain motions.	
		C. Inability to assume certain positions.	
		D. Other medical reasons (*If yes, give reasons.*)	
		16. Have you ever been treated for a mental condition? (*If yes, specify when, where, and give details*).	
		17. Have you ever been denied life insurance? (*If yes, state reason and give details.*)	
		18. Have you had, or have you been advised to have, any operations? (*If yes, describe and give age at which occurred.*)	
		19. Have you ever been a patient in any type of hospitals? (*If yes, specify when, where, why, and name of doctor and complete address of hospital.*)	
		20. Have you ever had any illness or injury other than those already noted? (*If yes, specify when, where, and give details.*)	
		21. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (*If yes, give complete address of doctor, hospital, clinic, and details.*)	
		22. Have you ever been rejected for military service because of physical, mental, or other reasons? (*If yes, give date and reason for rejection.*)	
		23. Have you ever been discharged from military service because of physical, mental, or other reasons? (*If yes, give date, reason, and type of discharge: whether honorable, other than honorable, for unfitness or unsuitability.*)	
		24. Have you ever received, is there pending, or have you applied for pension or compensation for existing disability? (*If yes, specify what kind, granted by whom, and what amount, when, why.*)	

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.
I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record for purposes of processing my application for this employment or service.

TYPED OR PRINTED NAME OF EXAMINEE	SIGNATURE

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL OFFICER ONLY."
25. Physician's summary and elaboration of all pertinent data (*Physician shall comment on all positive answers in items 9 through 24. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.*)

TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	DATE	SIGNATURE	NUMBER OF ATTACHED SHEETS

REVERSE OF STANDARD FORM 93

*U.S. Government Printing Office: 1989-241-775/80263

Applicant Must Complete
This Page (Except For Shaded Areas)
PLEASE PRINT

Copy of FAA Form 8500-8 (Medical Certificate) or FAA Form 8420-2 (Medical and Student Pilot Certificate) Issued: **EE.**

MEDICAL CERTIFICATE _____ CLASS
AND STUDENT PILOT CERTIFICATE

This certifies that (*Full name and address*):

Date of Birth	Ht.	Wt.	Hair	Eyes	Sex

has met the medical standards prescribed in Part 67, Federal Aviation Regulations, for this class of Medical Certificate.

Limitations

Date of Examination | Examiner's Serial No.

Examiner Signature / Typed Name

AIRMAN'S SIGNATURE

1. Application For: ☐ Airman Medical Certificate ☐ Airman Medical and Student Pilot Certificate
2. Class of Medical Certificate Applied For: ☐ 1st ☐ 2nd ☐ 3rd
3. Last Name / **First Name** / **Middle Name**
4. Social Security Number - -
5. Address Number/Street / Telephone Number ( ) / City / State/Country / Zip Code
6. Date of Birth M M D D Y Y
7. Color of Hair
8. Color of Eyes
9. Sex
10. Type of Airman Certificate(s) Held: ☐ None ☐ ATC Specialist ☐ Flight Instructor ☐ Recreational ☐ Airline Transport ☐ Flight Engineer ☐ Private ☐ Other ☐ Commercial ☐ Flight Navigator ☐ Student
11. Occupation
12. Employer
13. Has Your FAA Airman Medical Certificate Ever Been Denied, Suspended, or Revoked? ☐ Yes ☐ No If yes, give date M M Y Y
Total Pilot Time (Civilian only) **14. To Date** / **15. Past 6 months**
16. Date of Last FAA Medical Application M M Y Y ☐ No Prior Application
17. Do You Currently Use Any Medication (Prescription or Nonprescription)? ☐ Yes ☐ No If yes, give name, purpose, dosage, and frequency.

18. Medical History — Have you ever had or have you now any of the following? Answer "yes" for every condition you have ever had in your life. In the EXPLANATION box below, you may note "PREVIOUSLY REPORTED, NO CHANGE" only if the explanation of the condition was reported on a prior application for an airman medical certificate and there has been no change in your condition. **See Instructions Page**

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a. ☐	☐	Frequent or severe headaches	g. ☐	☐	Heart or vascular trouble	m. ☐	☐	Mental disorders of any sort; depression, anxiety, etc.	r. ☐	☐	Military medical discharge
b. ☐	☐	Dizziness or fainting spell	h. ☐	☐	High or low blood pressure	n. ☐	☐	Substance dependence or failed a drug test ever; or substance abuse or use of illegal substance in the last 5 years.	s. ☐	☐	Medical rejection by military service
c. ☐	☐	Unconsciousness for any reason	i. ☐	☐	Stomach, liver, or intestinal trouble				t. ☐	☐	Rejection for life or health insurance
d. ☐	☐	Eye or vision trouble except glasses	j. ☐	☐	Kidney stone or blood in urine	o. ☐	☐	Alcohol dependence or abuse	u. ☐	☐	Admission to hospital
e. ☐	☐	Hay fever or allergy	k. ☐	☐	Diabetes	p. ☐	☐	Suicide attempt			*See v, & w. Below*
f. ☐	☐	Asthma or lung disease	l. ☐	☐	Neurological disorders; epilepsy, seizures, stroke, paralysis, etc.	q. ☐	☐	Motion sickness requiring medication	x. ☐	☐	Other illness, disability, or surgery

Conviction and/or Administrative Action History — See Instructions Page

Yes	No		Yes	No	
v. ☐	☐	History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug, or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in the denial, suspension, cancellation, or revocation of driving privileges or which resulted in attendance at an educational or a rehabilitation program.	w. ☐	☐	History of nontraffic conviction(s) (misdemeanors or felonies).

Explanations: **See Instructions Page**

For FAA Use Review Action Codes

19. Visits to Health Professional Within Last 3 Years. ☐ Yes (explain below) ☐ No **See Instructions Page**

Date	Name, Address, and Type of Health Professional Consulted	Reason

- NOTICE -

Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both. (18 U.S. Code Sess. 1001; 3571).

20. Applicant's National Driver Register and Certifying Declarations

I hereby authorize the National Driver Register (NDR), through a designated State Department of Motor Vehicles, to furnish to the FAA information pertaining to my driving record. This consent constitutes authorization for a single access to the information contained in the NDR to verify information provided in this application. Upon my request, the FAA shall make the information received from the NDR, if any, available for my review and written comment. Authority: 23 U.S. Code 401, Note.

NOTE: **All persons using this form must sign it. NDR consent, however, does not apply unless this form is used as an application for Medical Certificate or Medical Certificate and Student Pilot Certificate.**

I hereby certify that all statements and answers provided by me on this application form are complete and true to the best of my knowledge, and I agree that they are to be considered part of the basis for issuance of any FAA certificate to me. I have also read and understand the Privacy Act statement that accompanies this form.

Signature of Applicant / Date M M D D Y Y

FAA Form 8500-8 (7-92) Supersedes Previous Edition — OMB Approval No. 2120-0034

Verify that this is the correct version before use

NOTE: FAA's Copy of the Report of Medical Examination Must be TYPED.

REPORT OF MEDICAL EXAMINATION

21. Height (inches)	22. Weight (pounds)	23. Statement of Demonstrated Ability (SODA) ☐ YES ☐ NO Defect Noted:	24. SODA Serial Number

CHECK EACH ITEM IN APPROPRIATE COLUMN	Normal	Abnormal	CHECK EACH ITEM IN APPROPRIATE COLUMN	Normal	Abnormal
25. Head, face, neck, and scalp			37. Vascular system (Pulse, amplitude and character, arms, legs, others)		
26. Nose			38. Abdomen and viscera (Including hernia)		
27. Sinuses			39. Anus (Not including digital examination)		
28. Mouth and throat			40. Skin		
29. Ears, general (Internal and external canals; Hearing under item 49)			41. G-U system (Not including pelvic examination)		
30. Ear Drums (Perforation)			42. Upper and lower extremities (Strength and range of motion)		
31. Eyes, general (Vision under items 50 to 54)			43. Spine, other musculoskeletal		
32. Ophthalmoscopic			44. Identifying body marks, scars, tattoos (Size & location)		
33. Pupils (Equality and reaction)			45. Lymphatics		
34. Ocular motility (Associated parallel movement, nystagmus)			46. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)		
35. Lungs and chest (Not including breasts examination)			47. Psychiatric (Appearance, behavior, mood, communication, and memory)		
36. Heart (Precordial activity, rhythm, sounds, and murmurs)			48. General systemic		

NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

49. Hearing	Right Ear	Left Ear		Right Ear					Left Ear				
Voice Test			Audiometer Threshold in Decibels	500	1000	2000	3000	4000	500	1000	2000	3000	4000

50. Distant Vision			51. Near Vision			52. Color Vision
Right	20/	Corrected to 20/	Right	20/	Corrected to 20/	☐ Normal ☐ Abnormal
Left	20/	Corrected to 20/	Left	20/	Corrected to 20/	
Both	20/	Corrected to 20/	Both	20/	Corrected to 20/	

53. Field of Vision	54. Heterophoria 20' (in prism diopters)	Esophoria	Exophoria	Right Hyperphoria	Left Hyperphoria
☐ Normal ☐ Abnormal					

55. Blood Pressure (Sitting; mm of Mercury)	Systolic	Diastolic	56. Pulse (Resting)	57. Urinalysis (If abnormal, give results) ☐ Normal ☐ Abnormal	Albumin	Sugar	58. ECG (Date) MM	DD	YY
		/							

59. Other Tests Given

60. Comments on History and Findings: AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECGs, X-rays, etc. to this report before mailing.

FOR FAA USE
Pathology Codes:
Coded By:
Clerical Reject

Significant Medical History ☐ YES ☐ NO Abnormal Physical Findings ☐ YES ☐ NO

61. Applicant's Name

62. Has Been Issued — ☐ Medical Certificate ☐ Medical & Student Pilot Certificate
☐ **No Certificate Issued** — Deferred for Further Evaluation
☐ **Has Been Denied** — Letter of Denial Issued (Copy Attached)

63. Disqualifying Defects (List by item number)

64. Medical Examiner's Declaration — I hereby certify that I have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.

Date of Examination MM DD YY	Aviation Medical Examiner's Name	Aviation Medical Examiner's Signature
	Street Address	AME Serial Number
	City State Zip	AME Telephone ( )

FAA Form 8500-8 (7-92) Supersedes Previous Editions

REPORT OF MEDICAL EXAMINATION

Applicant Must Complete This Page

PLEASE PRINT

1. Application For: ☐ Micro-Gravity Flight	2. Last Name	First Name	Middle Name

3. SSN	4. Address (Number/Street)	City	State/Country	Zip Code	Telephone No. ( )

5. DOB	6. Color of Hair	7. Color of Eyes	8. Sex	9. Occupation	10. Employer

11. Do you Currently Use Any Medication (Prescription or Nonprescription)?
☐ Yes ☐ No If yes, give name, purpose, dosage, and frequency.

12. Medical History - Have you ever had or have you now any of the following? Answer "yes" for every condition you have ever had in your life.

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
a. ☐	☐	Frequent or severe headaches	i. ☐	☐	Stomach, liver, or intestinal trouble	q. ☐	☐	Motion sickness requiring medication
b. ☐	☐	Dizziness or fainting spell	j. ☐	☐	Kidney stone or blood in urine	r. ☐	☐	Military medical discharge
c. ☐	☐	Unconsciousness for any reason	k. ☐	☐	Diabetes	s. ☐	☐	Medical rejection by military service
d. ☐	☐	Eye or vision trouble except glasses	l. ☐	☐	Neurological disorders; epliepsy, seizures, stroke, paralysis, etc.	t. ☐	☐	Rejection for life or health insurance
e. ☐	☐	Hay fever or allergy	m. ☐	☐	Mental disorders of any sort depression, anxiety, etc.	u. ☐	☐	Admission to hospital
f. ☐	☐	Asthma or lung disease	n. ☐	☐	Substance dependence or failed a drug test ever, or substance abuse or use of illegal substance in the last 5 years			
g. ☐	☐	Heart or vascular trouble	o. ☐	☐	Alcohol dependence or abuse	x. ☐	☐	Other illness, disability, or surgery
h. ☐	☐	High or low blood pressure	p. ☐	☐	Suicide attempt			

Explanations:

13. Visits to Health Professional Within Last 3 Years. ☐ Yes (explain below) ☐ No

Date	Name, Address, and Type of Health Professional	Reason

-NOTICE-

Whoever in any matter within the jurisdiction of any department or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme, or device a material fact, or who makes any false, fictitious or fraudulent statements or representations, or entry, may be fined up to $250,000 or imprisoned not more than 5 years, or both. *(18 U.S. Code Secs. 1001; 3571)*

Signature of Applicant	Date

JSC Form 8500 (Sep 97) (MS Word Sep 97)

Report of Medical Examination Must be TYPED.

14. Height (inches)			15. Weight (pounds)		
CHECK EACH ITEM IN APPR. COLUMN	Normal	Abnormal	CHECK EACH ITEM IN APPR. COLUMN	Normal	Abnormal
16. Head, face, neck, and scalp			28. Vascular system (Pulse, amplitude and character, arms, legs, others)		
17. Nose			29. Abdomen and viscera (including hernia)		
18. Sinuses			30. Anus (Not including digital examination)		
19. Mouth and throat			31. Skin		
20. Ears, general (internal and external canals: Hearing under item 49)			32. G-U system (Not including pelvic examination)		
21. Ear Drums (Perforation)			33. Upper and lower extremities (Strength and range of motion)		
22. Eyes, general (Vision under items 50 to 54)			34. Spine, other musculoskeletal		
23. Ophthalmoscopic			35. Identifying body marks, scars, tattoos (Size & location)		
24. Pupils (Equality and reaction)			36. Lymphatics		
25. Ocular motility (Associated parallel movement, nystagmus)			37. Neurologic (Tendon reflexes, equilibrium, senses, cranial nerves, coordination, etc.)		
26. Lungs and chest (Not including breasts examination)			38. Psychiatric (Appearance, behavior, mood, communication, and memory)		
27. Heart (Precordial activity, rhythm, sounds, and murmurs)			39. General systemic		

NOTES: Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.

40. Hearing	Right Ear	Left Ear		Right Ear					Left Ear				
Voice Test			Audiometer *Threshold in Decibels*	500	1000	2000	3000	4000	500	1000	2000	3000	4000

41. Distant Vision		42. Near Vision		43. Color Vision
Right 20/	Corrected to 20/	Right 20/	Corrected to 20/	
Left 20/	Corrected to 20/	Left 20/	Corrected to 20/	
Both 20/	Corrected to 20/	Both 20/	Corrected to 20/	☐ Normal ☐ Abnormal

44. Field of Vision	45. Heterophoria 20' (in prism diopters)	Esophoria	Exophoria	Right Hyperphoria	Left Hyperphoria
☐ Normal ☐ Abnormal					

46. Blood Pressure (Sitting mm of Mercury)	Systolic / Diastolic	47. Pulse (Resting)	48. Urinalysis (if abnormal, give results) ☐ Normal ☐ Abnormal	Albumin	Sugar	49. ECG (Date) MM / DD / YY
	/					

50. Other Tests Given

51. **Comments on History and Findings:** AME's summary and elaboration of all pertinent data *(AME shall comment on all positive answers in item 12. AME may develop by interview any additional medical history he deems important, and record any significant findings here.)*AME shall comment on all "YES" answers in the Medical History section and for abnormal findings of the examination. Use additional sheets if necessary and attach to this form.

Significant Medical History ☐ Yes ☐ No Abnormal Physical Findings ☐ Yes ☐ No

52. Applicant's Name	53. Disqualifying Defects (List by item number)

54. Medical Examiner's Declaration - I hereby certify that I have personally reviewed the medical history and personaly examined the applicant named on this medical examination report. This report with any attachment embodies my findings completely and correctly.

Date of Examination MM / DD / YY	Aviation Medical Examiner's Name	Aviation Medical Examiner's Signature
	Street Address	
		AME Serial Number
	City State Zip	AME Telephone ( )

JSC Form 8500 (Sep 97) (MS Word Sep 97)